DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from April 25, 2011 through May 2, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 93. The survey Stage 2 sample totaled thirty-eight (38) residents.	F 000		
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5/24/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview with activity staff, it was determined that the facility failed to account for three residents' (R17, R18, R11) personal funds that were being managed by activity personnel. Findings include: An interview with E4 (Activity staff) on 4/28/11 at 9:08 AM revealed that she held money for R17 at the resident's (or family members) request. E4 stated that she held $25 for R17 after R17 lost $20 at the facility six months ago. The facility had no procedures or system in place for to account for residents' funds. Interview with E5 (Corporate accountant) on	F 159	The Policy/Procedure to correct this deficiency was completed prior to the end of the survey. As the deficiency states, there were three residents involved with the practice in question. All three residents (R 11, 17 and 18) have been properly receipted per our Policy/Procedure. The Policy/Procedure has been put into place; all Activities Staff has been inserviced. The Policy/Procedure provides for random facility or corporate audits. The results of these audits will be reviewed at QAA every 3 months to assure compliance.	6/14/11 RK

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F 159	Continued From page 2 4/29/11 at 11:55 AM revealed that the activities department was holding money at the time for a total of three (3) residents. R18 ($34), R17 ($13) and R11 ($15). E5 stated a procedure would be put in place to address the accounting of residents' funds by activity staff. A procedure was provided to the surveyor by E1 (administrator) on 4/28/11 to address the accounting of residents' funds handled by activity staff.	F 159		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of other documentation as indicated and interview, it was determined that the facility failed to provide services that met professional standards of quality for 1 (R51) out of 38 sampled residents. The facility failed to perform a comprehensive wound evaluation and ongoing weekly wound evaluations for R51. Findings include: cross-refer to F314 According to the " Pressure Ulcer Treatment-Quick Reference Guide" developed by the NPUAP and EPUAP (National/European Pressure Ulcer Advisory Panel) 2009, stated, "... Assess the pressure ulcer initially and re-assess it at least weekly, documenting findings...".	F 281	Services provided or arranged by the facility will meet professional standards of quality. R51 is no longer residing at the facility. Residents in the facility have been evaluated to ensure accurate and ongoing initial wound assessments, weekly wound assessments, measurements, and staging. Licensed nursing staff has been educated on initial wound assessments, weekly wound assessments, measurements, and staging. Nursing will complete random audits of residents with wounds to ensure compliance for initial wound assessments, weekly wound assessments, measurements, and staging. Results of these random audits will be reviewed at the Quality Assurance Assessment (QAA) meeting to maintain compliance.	6/15/11 RHB

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F 281	Continued From page 3 R51 was admitted to the facility on 12/14/10 with a stage 2 pressure sore on the sacral area. The facility failed to perform an initial wound evaluation on 12/14/10 and weekly wound evaluations on 12/21/10 and 1/5/11(one was completed on 1/10/11). There were no comprehensive wound evaluations from admission until 13 days later when the sacral wound progressed from stage 2 to unstageable. Findings were confirmed with E2 (Director of Nursing) on 5/2/11.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, review of other documentation as indicated and interview, it was determined that the facility failed to ensure accurate, ongoing weekly wound assessments and they failed to consistently stage a sacral pressure sore accurately for 1 (R51) out of 38 sampled residents. Findings include: The facility policy "Pressure Sores", revised 3/2011 stated, "...Weekly measurements will be	F 314	R51 is no longer residing at the facility. Residents in the facility have been evaluated to ensure accurate and ongoing initial wound assessments, weekly wound assessments, measurements, and staging. Licensed nursing staff has been educated on initial wound assessments, weekly wound assessments, measurements, and staging. Nursing will complete random audits of residents with wounds to ensure compliance for initial wound assessments, weekly wound assessments, measurements, and staging. Results of these random audits will be reviewed at the Quality Assurance Assessment (QAA) meeting to maintain compliance.	6/15/11

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F 314	Continued From page 4	F 314		

documented in the resident's chart...". The policy also included descriptions of wound stages.

R51 was admitted to the facility on 12/14/10 with hospice services. R51 was hospitalized for approximately 2 weeks on a ventilator prior to admission to the facility. Diagnoses for R51 included: end stage lung disease, cirrhosis, hepatitis C, failure to thrive, diabetes mellitus, bipolar disorder and ambulatory dysfunction.

Review of the hospital interagency nursing communication record, dated 12/14/10, stated that R51 had a 2x2 cm stage 2 (partial thickness loss of skin layers that presents as an abrasion, blister or shallow crater) pressure sore to the coccyx (in the sacral area).

Review of the facility admission nursing assessment, dated 12/14/10, stated that R51 had a "...2x2 decubis (sic) coccyx area...". The nursing assessment lacked staging (describes the extent of tissue damage) of the wound, however, a 12/14/10 nurse's note stated that it was a stage 2 pressure sore. Lantiseptic antiseptic was ordered on 12/14/10 to treat the wound daily and as needed with a 2x2 Tegaderm dressing.

R51 was care planned on 12/14/10 for maximum assistance with activities of daily living, including mobility. He was bed bound. On 12/15/10, R51 was care planned for short-term memory impairment and impaired decision-making ability. R51 was care planned on 12/14/10 for potential for skin breakdown secondary to frail/impaired skin on admission, incontinence, impaired mobility, poor fluid/nutrition intake, and other

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reasons. Interventions included: notify wound care nurse and MD of any changes in skin integrity and wound care consult as needed.

A physician's history and physical completed on 12/16/10 lacked documentation of any pressure sores.

On 12/24/10, R51 was care planned for a stage 2 sacral pressure sore (admitted with). Interventions included: document findings in admission note and on Weekly Pressure Sore Assessment Tool and Weekly Skin assessment by unit managers or designee. Document findings on tool. Follow up with Wound Care RN and/or physician for treatment needs and/or changes.

On 12/27/10 a nurse's note stated that R51's sacral area had a stage 2 pressure ulcer, 4x2 cm with well defined, irregular pink edges, and a yellow wound bed with scant serous drainage. Wound care was implemented as ordered with Santyl and a clean dry dressing.

On 12/27/10 a wound evaluation was completed and the sacral wound first observed as a stage 2 on admission was now listed as unstageable (unable to be adequately staged due to presence of eschar (thick, leathery black crust) or necrotic (dead) tissue) with 100% yellow slough (stringy, necrotic tissue).

The facility failed to perform a complete wound evaluation on 12/14/10 when the sacral pressure sore was identified and they failed to reassess it again on 12/21/10 (weekly). Additionally, E12 (RN) that assessed the wound as a stage 2 in the 12/27/10 nurse's note was inaccurate; the wound

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F 314	Continued From page 6 was unstageable as it had a yellow wound bed (slough). An initial wound consultation was done on 12/29/10 by a wound consultant used by the facility. The unstageable sacral wound was measured at 3x1.5x.1 cm (length/width/depth). Additionally, a left heel pressure ulcer was identified at stage 2. On 1/3/11 R51 was care planned for an unstageable sacral pressure sore and a stage 2 pressure sore to the left heel. On 1/4/11 R51 was care planned for a declining condition related to terminal illness, on hospice- weight loss expected, no weights. A progress note, dated 1/4/11, stated that the nurse practitioner (NP) was asked to evaluate the sacral wound by nursing. The wound was described as a stage 3 approximately 1" long oval, 1/2" deep, with a small amount of clear drainage, and no surrounding inflammation. Treatment included Santyl and diapulse. The NP recommended that R51 be encouraged to eat and to see the wound nurse next week. R51's sacral pressure sore was re-evaluated by the wound care nurse on 1/10/11 (the weekly evaluation for wound monitoring was due on 1/5/11). The sacral wound was basically unchanged, but the left heel pressure ulcer was nearly healed. Although weekly skin checks were done by the facility as ordered on 12/14/10, the sacral area was just circled each week. Review of treatment records indicated that wound treatments were	F 314		

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F 314	Continued From page 7 provided as ordered. Despite daily observations of R51's worsening sacral wound there was no evidence in the clinical record that facility staff notified the residents family, hospice, the wound care consultant or the physician until 12/27/10 of the decline in R51's sacral wound from a stage 2 to unstageable over the past 13 days. Additionally, the facility failed to perform weekly wound assessments as per the care plan and facility policy. Lastly, the facility failed to accurately stage the sacral pressure sore on 12/27/10 when E12 (RN) incorrectly staged R51's wound as a stage 2 when it was unstageable. During an interview with E2 (Director of Nursing) on 5/2/11, E2 confirmed the missing wound assessments and the inaccuracy of the wound staging in the 12/27/10 nurse's note. She stated, "I must have missed that." E2 additionally stated that the QA committee began reviewing pressure sores in mid March.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that the resident's environment remained as free from	F 323	F323 Toilet Seats: All loose toilet seat handrails have been tightened. All resident toilets have been checked. All toilets will be checked in all future Resident Room Checks; these checks are done monthly by the Director of Maintenance. Any problems noted by the Director of Maintenance will be reported directly to the Administrator for immediate action.	

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F 323	Continued From page 8 accident hazards as was possible as evidenced by loose toilet seat handrails, and cords and wires on residents room floors posing accident hazards. Observations on 4/25/11 and 4/27/11 revealed loose toilet seat handrails in the shared bathrooms of rooms 204, 215, 216/217, 306, 311, 314/315, 318 and 321/322. The rails were loose and posed a fall risk. Additionally, observations made during the environmental tour on 4/27/11 revealed telephone, electrical bed and emergency call bell cords on the floor in resident rooms 303 and 325. This posed a potential fall risk. During an interview with E6 (Maintenance staff) on 4/27/11, E6 acknowledged this finding.	F 323	F323 Electrical cords All electric bed cords and emergency call cords (where length is at issue) have been bundled and tied. Telephone cords, and, where necessary, electrical cords have been attached to the adjacent walls by way of "power strips". All resident rooms have been checked, as noted above. This item will be checked monthly in our Room Check procedure. Any re-occurrence of this problem will be noted by the Administrator from the Monthly Resident Room Checks and will become part of the monthly Maintenance Report to QAA.	6/15/11 RK
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations of the dumpster area and staff interviews, it was determined that the facility failed to keep the lids on two of four dumpsters, storing garbage and refuse, tightly covered to prevent pest harborage. Additionally, debris was observed on the ground around the dumpsters. Findings include: Observations on 4/25/11 at 9:30 AM of the dumpster area outside the kitchen with E7 (Food	F 372	The matter of "closing dumpster lids" has, once again, been inserviced. At the time(s) of placing trash/garbage into the dumpster(s), the employee will observe if lids are in the closed position and make corrections if necessary. Any noted problem will be referred directly to the Administrator. There are no other similar garbage/trash issues in the facility.	

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F 372	Continued From page 9 Services Director) revealed a refuse dumpster (of four) with the top lids open. A second dumpster in the same area storing refuse had lids that were not tightly closed to prevent harborage of pests. Additionally, debris was observed on the ground around the dumpsters. Birds and small flies (nats) were observed feeding from the dumpsters. Interview with E7 (Food Services Director) on 4/25/11 confirmed this finding.	F 372	Inservices will continue; the Administrator will take any necessary corrective action. The Environmental Supervisor will monitor the trash area. The Administrator will take any corrective action.	6/15/11 RJR
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		

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F 431	Continued From page 10 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the drugs and biologicals that were stored in the medication cart and medication room were not expired and were labeled with expiration dates. Findings include: Observation on 4/28/11 of a second floor medication cart (one of two) with E8 (nurse) revealed one (1) package of Venlafaxine 37.5 mg and two (2) packets of Docusate sodium 100 mg tablets with no expiration or discard dates on the labels for R48. In an interview with E8 on 4/27/11 immediately after the observation, E8 confirmed these findings and left the medications in his cart. E8 stated the medications should have expiration dates, which is the standard protocol. Additionally, observation on 4/27/11 in the third floor medication room with E9 (nurse) revealed one (1) bottle of house stock Vitamin B1 tablets that had expired on 10/10. Review of facility procedure revealed that all medications received at the facility needed to have expiration dates.	F 431	The facility will ensure that the drugs and biologicals that are stored in the medication cart and medication room are not expired and are labeled with expiration dates. R48's medications were labeled with expiration/discard dates on April 28, 2011. At this time, R48 is no longer a resident in the facility. Stock medication in the third floor medication room was reviewed to ensure medications that were expired were discarded. All medications in the facility have been reviewed to ensure correct labeling with appropriate expiration dates and were corrected if indicated. All licensed staff has been educated on drug labeling and discarding expired medications. DON/designee will do random audits of medication carts and medication rooms to ensure labeling and discarding of expired medications. Results of the random audits will be reviewed at QAA meeting to maintain compliance.	6/15/11 RR

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F 431	Continued From page 11 Interview with E3 (ADON) on 5/2/11 revealed that they were receiving R48's medications from a new pharmacy medical insurance plan. E3 stated that R48's two medications were picked up by the pharmacy and relabeled. E3 also stated that the discard dates are equivalent to expiration dates for this pharmacy.	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to provide a safe and comfortable environment for the laundry staff in regards to air temperature of 94.5 degrees Fahrenheit detected in the laundry room dryer area. Observations of the laundry dryer area with E6 (maintenance staff) and E10 (Corporate District Manager) on 4/27/11 at 2:00 PM revealed that the air temperature of the room was 94.5 degrees Fahrenheit. The air temperature outside the facility was about 82 degrees Fahrenheit that day. A portable air conditioner and two fans (that were turned on) were observed in the room. Interview with E6 and E10 acknowledged this finding. Interview with E11 (Laundry staff) on 5/2/11 at 8:30 AM revealed that the air temperature of the laundry dryer area was very hot during the	F 465	Immediate action was taken by the turning "on" of an air conditioner in the room; a second air conditioner was added shortly thereafter. On today's date, May 24, 2011, a contractor, Industrial Mechanical, of Hatboro, Pa., has visited the facility and will complete a proposal for providing more air conditioning capacity into the laundry area. Only the employees assigned to work in the laundry area are affected by the room temperatures. Employees assigned to the laundry have been inserviced on the use of air conditioning equipment currently installed in the laundry. Employees have been inserviced to bring air temperature concerns to the attention of the Laundry Supervisor. The Administrator will do random audits to assure temperature compliance. The random audits will be reviewed at QAA to maintain compliance.	6/15/11 RK

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 12 summer months. E11 stated that at times the temperature of that room reached 105 degrees Fahrenheit in the summer. Additionally, observations of the laundry room on 4/25/11, 4/27/11 and 5/2/11 revealed the laundry dryer room door open to the hallway of the facility. E1 (Administrator) on 5/2/11 voiced disagreement with this finding stating that the staff can control the air conditioner in the room.	F 465		

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Regency Healthcare

DATE SURVEY COMPLETED: May 2, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from April 25, 2011 through May 2, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 93. The survey sample totaled thirty-eight (38) residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to the CMS 2567-L survey report date completed 5/2/11, F159, F281, F314, F323, F431, and F465.	State Report: Please cross refer to corresponding CMS survey dated 5/02/2011. 6/15/11 RR
3201.7.5	**Kitchen and Food Storage Areas.**	

Provider's Signature [signature] Title [signature] Date 5/24/11

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Facilities shall comply with the Delaware Food Code. **5-501.15 Outside Receptacles.** **(A) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.** **(B) Receptacles and waste handling units for refuse and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit.** Cross refer to the CMS 2567-L survey report date completed 5/2/11, F372.	